

## THIS ISSUE

• National Women's History Month!

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## THE ORIGINS OF THE INTRAUTERINE DEVICE

In order to understand the history of the IUD as a form of contraception, we must understand its development as an example of the biopolitics of contraception. Such an analysis is offered in Chikako Takeshita's work *The Global Biopolitics of the IUD: How Science Constructs Contraceptive Users and Women's Bodies*. Here, Takeshita traces the development and deployment of this contraceptive device over the course of several decades, describing how this technology was imbued with various different meanings by competing groups with highly varied interests.

Of major concern is Takeshita's treatment of the segregated discourses of contraception which apply differentially to women of the global North and women of the global South. Takeshita makes clear that women of the global North include dominant class women within the colonizing societies that constitute the global North. African-American women, for example, although geographically within the global North, are subject to much of the same oppression that stifles the liberation of women living in the

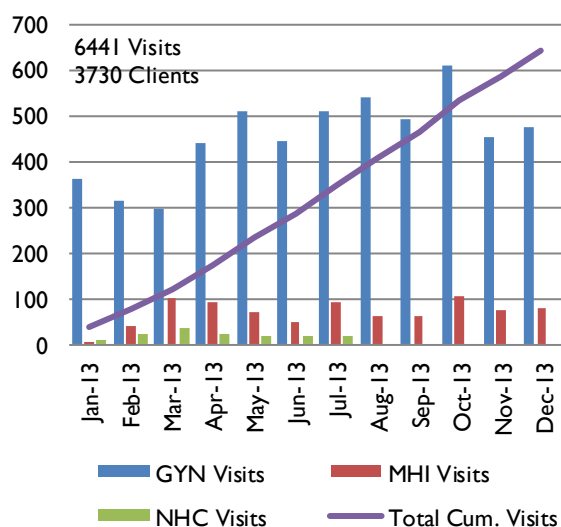
geographic global South. Takeshita's main claim is that although "curbing the birthrate of the poor and improving maternal health provide the framework for family planning in the global South, an entirely different set of concerns, such as profitability, liability, and health risks, determines the conditions of contraceptive use in the global North".

Takeshita argues that this differential treatment and subjectification under the contraceptive discourse is the product of separate apparatuses with divergent concerns about the meaning of contraceptive technology. On one side stands the Neo-Malthusian movement, a mid-20th century scientific movement that rediscovered British scholar Thomas Malthus's work on the catastrophic economic and ecological effects of overpopulation. This group funded contraceptive research to produce a contraceptive solution for masses of women in the global South who required a contraceptive method that was long-lasting, requiring health care access to remove, yet was not irreversible. On the other side were second wave feminists

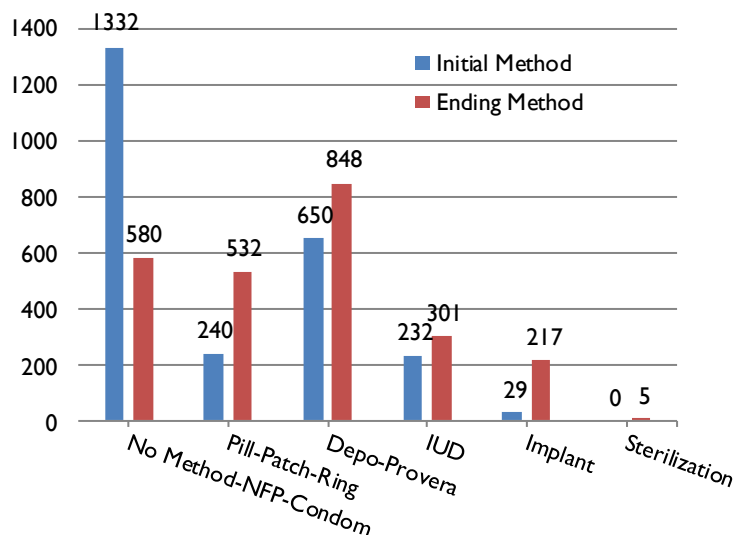
in the global North who wanted contraceptive methods that were efficacious, allowing for the equalization of gender participation in the economy, without being unsafe.

Takeshita describes how the IUD began as a method designed for biopolitical control of masses of women from the global South, but was later translated into an empowering method of birth control for affluent, dominant-class women in the global North. Many of these devices were extremely dangerous when first introduced in the mid-1950s and also lacked evidence for their efficacy in preventing pregnancy. Nonetheless, IUDs proliferated through the global South via organizations such as USAID and the International Planned Parenthood Federation before migrating back to the U.S. market where women were desperate for alternatives to the oral contraceptive. Even though women in the global South, especially in India, had all but forsworn use of the IUD because of its dangers, it was only through use in the United (continued on next page)

RHWP Visits by Month  
For 2013



Method Changes for Female Clients Seeking Contraception  
For 2013



## ABORTION DECLINES IN THE UNITED STATES

It has been reported recently that the abortion rate in the United States has reached the lowest point since *Roe vs. Wade* was passed in 1973. Rates when *Roe vs. Wade* was passed were around 16.3 per 1000, and reached a peak in 1981 at 29.3 per 1000. Since then, the rates have been declining (with a few spikes in the 1990s and around 2005) and reached 16.9 per 1000 in 2011<sup>2</sup>. While it appears that the numbers of abortions climbed significantly after abortion became legal at the federal level, in reality, this could simply be due to the fact that the number of legal abortions was on the rise. There is no way to know how many illegal and dangerous abortions (often called back-alley or coat hanger abortions) took place before, or have occurred since abortion became legal in the United States.

The number of these unsafe abortions will likely increase if continued restrictions on legal abortions are put in place by states. A summary of two studies conducted by the World Health Organization and Guttmacher Institute about worldwide abortion safety states that “while almost all reported abortions were deemed safe in North America and Europe, nearly all abortions (97 percent) in Africa were considered unsafe in 2008. Nearly all abortions were performed under safe conditions in East Asia, but 65

percent were considered unsafe across south central Asia”<sup>3</sup>. This demonstrates that despite a lack of access, women do not stop getting abortions.

The study published by the Guttmacher Institute shows a decline in abortion rates overall, state that “the study did not specifically investigate reasons for the decline... [but] note that the study period (2008-2011) predates the major surge in state-level abortion restrictions that started during the 2011 legislative season, and that many provisions did not go into effect until late 2011 or even later”<sup>2</sup>. The authors go on to discuss that the closure of 1% of existing abortion clinics and the decline of abortion providers by 4%, writing “with abortion rates falling in almost all states, our study did not find evidence that the national decline in abortions during this period was the result of new state abortion restrictions. We also found no evidence that the decline was linked to a drop in the number of abortion providers during this period”<sup>2</sup>. While the decline in the number of abortion clinics and providers can make it more difficult to obtain an abortion because of travel constraints some women face, it is not a significant enough reduction in num-

bers to be the cause of the rate changes.

While the study did not specifically investigate reasons for the decline in the number of abortions, the authors speculate that the reduction corresponds to an overall increase in the number of women utilizing contraception, especially the long acting reversible methods, to delay pregnancy. The authors write “the decline in abortions coincided with a steep national drop in overall pregnancy and birth rates... [and] the recent recession led many women and couples to want to avoid or delay pregnancy and childbearing”<sup>2</sup>. Giving all women safe and accessible abortions is not going to make the number of abortions skyrocket, nor is giving them easy and affordable access to contraception going to encourage women to have more sex. Ignoring the fact that some people will have abortions no matter the restrictions, and people will continue to have sex whether they are protected or not is short-sighted and narrow minded. If your goal is to reduce the number of abortions occurring in the US and the rest of the world, putting people in the best situation to prevent unplanned pregnancies is simply the easiest way to do that.

## THE ORIGINS OF THE IUD (CONT.)

States among women desiring long-acting birth control methods that the dangers of the IUD became visible to the scientific community. One method in particular, the Dalkon Shield, was shown to have killed some 15 women in the U.S. When the dangers of the device became palpable, there was justified outrage among feminists who claimed corruption among manufacturers of these devices. Thus, the IUD lost momentum in the U.S. However, feminist backlash spurred development of a more effective, safer IUD within the Neo-Malthusian scientific apparatus. Through mediation by the dominant class of contraceptive users, the IUD itself was reconstituted into a safer form of contraception while the IUD recipient was similarly reconstructed into a dominant class woman. Takeshita says, “Multiple biopolitical scripts also emerged as coproducts of implicated users, ranging from fertility restriction of racial minorities and lower-class women in the United States and prevention of white middle-class teen pregnancies to the preclusion of young, ‘promiscuous,’ and childless women from IUD insertions”<sup>1</sup>. We can see through this example of the IUD’s transformation how the biopolitics of contraception can operate to change the meaning inscribed to this technology.

## THE FUTURE OF BIRTH CONTROL FOR MEN

Improvement in reproductive rights has given women the opportunity to attain more freedom and control over their lives. There has been plentiful research into the improvement of female birth control, while there has been significantly less research done on male birth control. Although condoms are very effective at preventing STIs and pregnancy when always used correctly, human error associated with condoms can lead to more unplanned pregnancies than with the birth control pill, LARCs, or other methods controlled by women.

There are several promising methods of male birth control in development. Dr. Nnaemeka Amobi and his team are doing research into a “clean sheets pill”<sup>4</sup>. This pill prevents male ejaculation while leaving the pleasure associated with orgasm intact. An advantage of this method is that without seminal fluid there will be a lower chance of sexually transmitted infection transmission.

There has also development into a birth control pill for men called JQ1. This drug stops the testes from making a protein essential for sperm growth<sup>4</sup>. In mice that are given JQ1, the number of sperm dramatically decreases and the rest are infertile due to reduced motility.

Despite the fact that men are impacted

by unintended pregnancies as well, the ability to control fertility is usually dependent on women’s use of hormonal contraception. Since many women encounter side effects from available contraceptive methods. It would be very convenient to have additional options for men.

There are many who wonder if men would be willing to use non-traditional methods of birth control. However, a recent study has shown that 70% of men would be willing to take a male birth control pill if there was one available<sup>5</sup>. It is senseless to ignore half of the population that is involved in reproduction when there are many men are willing to use medicalized forms of birth control.



## TEAM MEMBER SPOTLIGHT: KWASI FREMPONG

**Name:** Kwasi Frempong-Boadu

**Hometown:** Accra, Ghana

**Favorite book:** Da Vinci Code

### What do you do at the body shop?

I am an intern for the men's health initiative working under the direct supervision of Dr. Jennifer Mooney and Mr. Eric Washington. I am interested in learning in every way possible about the Cincinnati Health Department and the wide range of services provided to improve reproductive health and wellness.



### What do you love about working in reproductive health?

Reproductive health accounts for various facets of emotional and physical complications that may arise later in life. By being able to properly care for a mother pre-conception, or better involve a father in the family planning process, we can improve a wide range of outcomes in most cases.

### When you're not at the body shop, where might we find you?

I might be found at the other "body shop" Aka the gym. You can usually find me at the library as well doing research and working on assignments. In the summer, I frequent the soccer field on campus for pick up games. If you are not lucky, you might not find me at all, because I tend to travel as much as my schedule allows me to.

## KATHERINE MCCORMICK: THE PHILANTHROPIST BEHIND THE PILL

The reproductive rights movement in the United States has had many influential women at its helm, but few have had as large of an impact as Katherine McCormick. If you haven't heard of her, you should know that birth control would be vastly different without her. She was an ally of Margaret Sanger during the women's suffrage movement and a continued colleague and advocate for other advancements in women's rights, (reproductive and otherwise,) becoming the vice-president of the Women's Voter's League at the onset of women's suffrage<sup>6</sup>. Beyond this, she was a successful biologist, was only the second woman to graduate from MIT<sup>7</sup>, and was a philanthropist who provided the essential funding for developing the first birth control pill.

Katherine inherited 10 million dollars in 1937 following the death of her mother. Her husband, Stanley, passed away in 1947 after a long battle with schizophrenia. She became the benefactor of to his estate worth over 35 million dollars<sup>8</sup>, with which started several philanthropic projects. Katherine decided to forego having any children of her own<sup>8</sup>, believing that

the schizophrenia her husband suffered from was hereditary. Birth control was underdeveloped at this time, with the suppository and douche being used as the primary methods of birth control in the United States<sup>6</sup>. These methods were far from perfect and she was determined to improve upon them.

Birth control is a hot issue today, but as an even hotter issue in the early 20<sup>th</sup> century. During this time thirty states had laws prohibiting the sale and use of artificial birth control. Despite this, Gregory Pincus was doing new research into the hormones controlling pregnancy in women. Unfortunately, his research was to be discontinued because it had not yet turned a profit. McCormick met with Sanger and Pincus, and she took it upon herself to make easy to use, female-controlled contraception a reality. She donated 2 million dollars, today roughly equivalent to 23 million, to help Pincus continue his development<sup>6</sup>.

This display of philanthropy and foresight allowed for the development of a new form of birth control in 1960, the contraceptive pill. Today the pill has become one of the most

widely utilized contraceptive methods around the world. If not for the efforts of this philanthropic scholar, reproductive control would have been inhibited for quite a long time.



*Katherine McCormick*

## MEN'S HEALTH

Interested in the Men's Health Initiative for your organization?  
Contact the program coordinator:  
eric.washington@cincinnati-oh.gov

### MAN TO MAN:

The Men's Health Initiative provides clinical services to young men at the Clement Health Center! It's located on the corner of Burnet Ave. and MLK. You can walk-in and get an appointment at to see a health care provider for an STI screening. After that, you'll receive a Men's Health Initiative counseling session!





# REPRODUCTIVE HEALTH & WELLNESS PROGRAM

Reproductive Health Suite  
Clement Health Center  
Cincinnati Health Department  
3101 Burnet Avenue  
Cincinnati, OH 45229

RHWP Hotline:  
513-357-7341

Appointment scheduling through  
the CHD Call Center:  
513-357-7320

**The Reproductive Health and Wellness Program (RWHP) or the body shop**, is a five-year grant awarded by the Ohio Department of Health to the Cincinnati Health Department and is funded by the federal Title X program. The primary objective of this program is to provide access to contraceptives and reproductive health services to the men and women of Hamilton County, especially to the most underserved populations, so as to reduce the number of unplanned pregnancies, unwanted pregnancies, and ultimately, the number of poor pregnancy outcomes. Through these direct services, education and outreach, the program also hopes to cultivate a culture of responsibility, well-being, and empowerment in regards to sexuality and reproductive health. To date, we've enrolled over 4,000 individuals, and continue to grow, learn, and serve.

For additional information regarding the project, please contact Dr. Jennifer Mooney at:

jennifer.mooney@cincinnati-oh.gov

## March is Women's History Month!

We want all women (and men) to be confident and successful, so don't forget to prevent STIs and unplanned pregnancy!

Wonder Woman thinks you should use birth control, too!



## REFERENCES

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